Health insurance for all kids

Wisconsin
BadgerCare Plus Program
Proposal

Wisconsin Department of Health and Family Services

EXECUTIVE SUMMARY

In announcing his "Affordability Agenda" in January 2006, Governor Jim Doyle stated that "no child should ever be without health insurance." The policy solution to ensure that all of Wisconsin's children have access to health care is creation of a single health care safety net—BadgerCare Plus. This proposal describes Wisconsin's strategies for achieving the four strategic goals of the initiative.

- ★ Cover all children
- ★ Provide coverage and enhanced benefits for pregnant women
- ★ Make the program simple
- ★ Promote prevention and healthy behaviors

BadgerCare Plus will merge Family Medicaid, BadgerCare, and Healthy Start[1] to form a comprehensive health insurance program for low income children and families. Coverage will be expanded to seven new populations.

1) All children (birth to age 19) with incomes above 185 percent of the federal poverty level (FPL)[2]
2) Pregnant women with incomes between 185 and 300 percent of the FPL
3) Parents and caretaker relatives with incomes between 185 and 200 percent of the FPL
4) Caretaker relatives with incomes between 44 and 200 percent of the FPL
5) Parents with children in foster care with incomes up to 200 percent of the FPL
6) Youth (ages 18 through 20) aging out of foster care
7) Farmers and other self-employed parents with incomes up to 200 percent of the FPL, contingent on depreciation calculations

In addition, Wisconsin will streamline eligibility; assist employees in purchasing quality, employer-sponsored coverage; and provide incentives for healthy behaviors. This proposal represents the most sweeping reform of the low-income, family portion of the Medicaid program in Wisconsin since its inception in 1967.

A key component of Wisconsin's BadgerCare Plus is implementation of a benchmark plan for the majority of the expansion population. This new benefit plan is adapted from the State's largest, low-cost commercial plan with four benefits added to ensure that the plan meets the needs of the targeted populations. Another key component is a focus on prevention and healthy living.

BadgerCare Plus will be budget neutral. The State believes that further expansion of managed care and administrative savings derived from dramatic simplification will be sufficient to fund BadgerCare Plus. Administrative savings alone are estimated at $14.5 million annually.[3] Wisconsin proposes to implement BadgerCare Plus through provisions in the Deficit Reduction Act of 2005 (DRA); state plan amendments through Medicaid and the State Children's Health Insurance

[1] The combined current enrollment of Family Medicaid, BadgerCare, and Healthy Start is approximately 554,000.
[2] The 2006 Federal Poverty Level guidelines for the 48 Contiguous States and the District of Columbia for a family unit of one is $9,800; two: $13,200; three: $16,600; four: $20,000; five: $23,400; and six: $26,800.
[3] The estimate includes both state and county administrative savings from simplifying and streamlining the eligibility process.

Program (SCHIP); and Section 1115 waivers of federal law and regulations as necessary. Should waivers be required, the State proposes that budget neutrality be established on a per member per month basis.

In addition, Wisconsin anticipates incorporating our current waiver for BadgerCare (SCHIP) into BadgerCare Plus to allow the State to claim enhanced federal matching for adults with incomes between 100 and 200 percent of the FPL. In the interim, the State will request an extension of the existing waiver. Wisconsin will work with the Centers for Medicare and Medicaid Services (CMS) to determine appropriate funding (Title XIX or Title XXI) for benefits and administration of the expansion.

BACKGROUND

Wisconsin has a long and proud tradition of offering its residents a comprehensive health care safety net. Still, far too many children and families do not have health insurance, and subsequently, lack access to affordable care. In 2004, an estimated 91,000 children went without health insurance for at least a portion of the year.[4] The inability to access health insurance not only affects the lives of children that go without care; it also affects all residents through higher health care costs over time, higher insurance premiums, and higher taxes.

BadgerCare Plus is designed to address four major problems with health insurance coverage in Wisconsin.

1) Increasing numbers of uninsured and a decreasing number of children and adults covered by employer-sponsored insurance plans
2) Lack of access to comprehensive, affordable health care for working families and pregnant women leading to poor health outcomes
3) Costly and complex eligibility rules that create barriers to obtaining health insurance coverage
4) Eligibility requirements that hinder family stability

Increasing Numbers of Uninsured

According to the 2003 and 2004 Wisconsin Health Insurance Surveys, the number of uninsured residents is on the rise. The lack of affordable health insurance is especially problematic for children aged 0 -17. Research indicates that health care coverage for children is relatively inexpensive. Research also confirms that investment in early, preventive care pays huge dividends over time. Yet, despite recent Medicaid expansions and the creation of BadgerCare (SCHIP), the number of uninsured children in Wisconsin continues to rise.

- In 2003, an estimated 26,000 children (2 percent of the total population) were without health insurance for the entire year. In 2004, the number of uninsured children climbed to 34,000 (3 percent of total).
- In 2003, an estimated 85,000 children (7 percent) were without health insurance for at least part of the year. In 2004, this number increased to 91,000.

[4] Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. "2004 Wisconsin Health Insurance Coverage Report."

- About 12 percent, or more than 10,000 children, without insurance were in families who are "near poor."[5]

Increases in the number of uninsured are due, in part, to fewer and fewer businesses offering their employees health insurance.

- In 2001, 76 percent of Wisconsin's residents had their health insurance provided by their employers. That number dropped to 69 percent in 2004.[6]
- A recent report from the Kaiser Commission on Medicaid and the Uninsured indicates that this number continues to decline.[7]
- Enrollment in Medicaid and BadgerCare has increased significantly since 2001, but not enough to avoid an increase in the rate of uninsured persons.
- In 2005, 7 percent of Wisconsin's residents were uninsured. The majority of these individuals were in working families.[8]

Lack of Access to Affordable Health Insurance and Poor Health Outcomes

Across the nation, the rising cost of health insurance continues to drive more and more families out of employer-sponsored insurance. A recent report from the Robert Wood Johnson Foundation indicates that spending on health care has grown rapidly since the 1960s, at an average of 10 percent per year.[9] Some, but not all, of these families can access the publicly-funded safety net—Medicaid and BadgerCare.

Health insurance costs in Wisconsin are especially high and growing. The total cost of employer-sponsored health benefits in Wisconsin increased 9.2 percent in 2005, to an average of $9,321 for each employee—31 percent more than the national average according to a survey by Mercer Health & Benefits, LLC.[10]

Employee premium contributions and out-of-pocket costs have been rising faster than wages, creating a growing "affordability gap" for employer-sponsored plans for low-income working families. In some cases, self-employed individuals, farm families, and employees of small firms without any health insurance plans may not be able to afford coverage for their children, even with incomes above 300 percent of the FPL.

The inability to access health insurance has consequences. The Institute of Medicine and others (Newacheck et al. 1998b. and McCormick et al., 2001) have found that uninsured children use medical and dental services less frequently and are less likely to get their prescriptions filled than insured children, even after taking into account differences in family income, race/ethnicity, and

[5] Ibid.
[6] Census Bureau. *Current Population Survey*. Historical Health Insurance Tables (Table HI-6 Health Insurance Coverage Status and Type of Coverage by State—People Under 65: 1987-2004.) Accessed on April 20, 2006.
[7] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Populations Survey (CPS: Annual Social and Economic Supplements).
[8] The Commonwealth Fund. "New Survey Finds Rising Numbers of Uninsured in Moderate- and Middle-Income American Families." April 26, 2006. New York, NY.
[9] Employee Benefit Research estimates from Centers for Medicare and Medicaid Services and U.S. Department of Commerce. 2006.
[10] "Health Benefit Costs Rose 9% in State in '05." Milwaukee Journal Sentinel, November 21, 2005. Accessed on April 12, 2006 at www.jsonline.com/story/index.aspx?id=372342.

health status. In addition, the studies found that uninsured children are less likely to receive routine, preventive well-child checkups and immunizations. Especially disturbing, half of all uninsured children have not had a doctor's visit in the past year, more than twice the rate of insured children.[11]

Complex and Costly Eligibility Rules

Medicaid was initially designed to provide health care coverage only for recipients of cash assistance. Over time, and with the reform of Aid to Families with Dependent Children (AFDC), Medicaid and its related programs have evolved from part of the welfare program to a health care safety net on which children and pregnant women in or near poverty, and unemployed, under-employed, and working poor parents rely to meet their health care needs. While this expansion of coverage has been welcomed, it has also created a patchwork of complex eligibility rules and laws that are very costly to administer and which often discourage qualified families from enrolling.

In addition to the many different groups covered in Wisconsin, the specific eligibility rules and various deductions and disregards from income for these programs are also very complicated. Many of these rules have their basis in the now-defunct AFDC program. These rules were developed at the time AFDC used dollar-for-dollar budgeting such that every additional dollar of household income reduced AFDC cash assistance unless partially or wholly disregarded, exempted, or deducted.

This is not the case for Medicaid where eligibility is determined on a pass/fail basis. The medical coverage benefit provided to a family that is $500 below the income limit is the same benefit provided to a family that is only $1 below the limit. This needless complexity calls for new financial eligibility criteria that are more congruous with the pass/fail dynamic and the new role of Medicaid as a health care program for low-income families, many of whom are working.

These vestigial rules also make it needlessly difficult for prospective applicants to determine if they might qualify for health insurance. This uncertainty means that many individuals and families may delay applying for assistance until they are very ill or suffer from an injury. These individuals subsequently often seek care from already overburdened health care resources such as hospital emergency rooms.

Wisconsin Medicaid continues to use the change reporting policies that were in place with the AFDC cash assistance program and were designed to change the amount of the cash benefit the family received from month-to-month based upon their financial status. The requirement that all changes be reported within ten days is an anachronism of that link to cash assistance. It also makes it difficult for families who are employed to retain continuous eligibility for a sustained period of time, even when they meet all of the requirements of the program without interruption. More than 25 percent of all children currently enrolled in Family Medicaid, BadgerCare, or Healthy Start programs have gaps in their eligibility because of these rules. These gaps last for a median length of three months hampering the ability of care management organizations, e.g., Health Maintenance Organizations (HMOs), to provide continuous preventive care. During these "gap" months, the HMO cannot provide the type of care that will keep the child healthy and his/her continuing health care costs low.

[11] "Insuring America's Health: Principles and Recommendations (2004). Board on Health, Institute of Medicine. Accessed on April 20, 2006 at www.darwin.nap.edu/books/0309091055/html.

Finally, the unnecessary administrative cost to process nearly 800,000 changes when many do not actually affect eligibility for Family Medicaid/BadgerCare results in expenditures of more than $12 million each year. Wisconsin believes that these funds would be better invested in providing health care services to more individuals.

Eligibility Requirements that Inhibit Family Stability

Under current policy, relatives who are caring for the sons and daughters of absent parents must have incomes below the AFDC Assistance Standard in order to qualify for Medicaid. Some of these caretaker relatives have children of their own and qualify as parents under BadgerCare. Many caretaker relatives, however, do not have minor children of their own, and can only qualify for Medicaid if their incomes are less than 50 percent of the FPL. While Wisconsin's Kinship Care program reimburses these families for care expenses, medical expenses are not included and many of these families are not eligible for Medicaid or BadgerCare.

In addition, parents who temporarily lose custody of their children to foster care due to substance abuse or untreated mental illness often do not have the ability to seek treatment since they no longer qualify for Medicaid or BadgerCare. This leads to a catch-22: the parent needs treatment services in order recover sufficiently to be reunified with his or her family, but the parent is not eligible for health care coverage until the family is reunited. For parents who are poor and without private health insurance, reunification becomes extremely difficult and unlikely.

Research indicates that stable adult relationships are critical to the healthy development of children. Helping support caretaker relatives who open their homes to grandchildren, nieces/nephews, and cousins and providing access to treatment for parents seeking to re-gain custody of their children helps Wisconsin achieve this goal.

CURRENT STATE

Like other states, Wisconsin's Medicaid programs are very complicated. For example, there are currently twenty different coverage groups, each with differing income levels and their own complex eligibility rules. Intake is similar for each group and the State has made great strides in simplifying access to services. Further complicating administration is the fact that different coverage groups have different cost sharing requirements. There are also two federal funding formulas each for benefit costs and administrative costs for Medicaid, BadgerCare, and Healthy Start. Finally, HMOs are reimbursed at three different capitation rates, each of which must be determined actuarially sound.

Eligibility

The Medicaid program has been significantly expanded since 1967 from a medical program just for the recipients of cash assistance to a health care safety net for low-income children, pregnant women, and caretakers of dependent children. This expansion was welcomed. At the same time, it added new income levels and, thus, new eligibility criteria and complexity. For example, there are currently eight different income tests for Medicaid, BadgerCare, and Healthy Start. In addition, federal law continues to require a complex array of income disregards and deductions further complicating the eligibility determination process.

In Wisconsin's current system, individuals who want to apply for state-sponsored health insurance must submit an application to a county or tribal income maintenance agency. The application may be submitted in person, over the telephone, through the mail, or via the Internet through the ACCESS web site.[12] Presumptive eligibility is determined by qualifying providers for pregnant women and as part of the Family Planning Waiver, but is not offered for children.

Benefits

Currently, all enrollees in Family Medicaid, BadgerCare, and Healthy Start receive the comprehensive Medicaid benefit package. Medicaid benefits include: prescription drugs; physician visits; hospitalization; dental and vision services; mental health and alcohol and drug addiction services; physical, occupational, and speech therapies; hospice care; Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services; nursing home and other long-term care services; case management; and emergency and non-emergency transportation services.

Premiums and Cost Sharing

Under Wisconsin's current system, all families enrolled in BadgerCare with incomes above 150 percent of the FPL are required to pay a monthly premium of five percent of their monthly income (excluding certain disregards and deductions). Participants below 150 percent of the FPL do not pay premiums.

Cost sharing in Family Medicaid, BadgerCare, and Healthy Start is minimal. There is a fifty cent to three dollar co-pay for prescription drugs; one to three dollars for physician visits; and other nominal co-pays. Individuals enrolled in managed care are not required to make co-payments.

Service Delivery

Approximately 70 percent of Wisconsin's Family Medicaid, BadgerCare, and Healthy Start population are enrolled in managed care through fourteen HMOs across the state. In areas where managed care is not available or in areas where Medical Assistance managed care enrollment is capped, individuals use fee-for-service.

Funding

Funding for Family Medicaid, BadgerCare, and Healthy Start is a combination of state general purpose revenue (GPR) funds, federal funds, and participant contributions. Family Medicaid and Healthy Start are funded at an approximate 58 percent federal/42 percent state split. The majority of the BadgerCare population is funded at an enhanced 71 percent federal match. Combined state fiscal year 2006 totals for all three programs were $1,174,751,385. This $1.1 billion provides services to more than 554,000 enrollees.[13]

[12] Implemented in 2004, ACCESS is an Internet-based tool that directly connects low-income consumers with public benefit programs. Potentially eligible individuals and service providers can use ACCESS to assess initial eligibility for FoodShare, Medicaid, BadgerCare, SeniorCare, WIC, school meals, summer food programs, emergency food assistance, and state and federal tax credits. The "Am I Eligible?" assessment tool is available in English and Spanish. Participants can also use the tool to check current benefits. Beginning in June 2006, Wisconsin residents can apply on-line for FoodShare, Medicaid, BadgerCare, and the Family Planning Waiver program. https://access.wisconsin.gov

[13] Wisconsin Medicaid Program and Monthly Medicaid Enrollment. June 2006. Dept. of Health and Family Services, Division of Health Care Financing.

STRATEGIC ALIGNMENT

The mission of the Department of Health and Family Services is to protect and promote the health and safety of the people of Wisconsin. A variety of strategies are employed to achieve this mission—all focused on improving the health and well-being of children, families, and adults. BadgerCare Plus will significantly increase access to quality health care for an estimated additional 28,000 children, pregnant women, parents, and caretaker relatives, thus, improving their health.

SCOPE

The following section outlines the parameters, constraints and assumptions BadgerCare Plus is built upon.

In-Scope

- Strategies for expanding state-sponsored health insurance to new populations of children, families, and pregnant women
- Strategies for consolidating and simplifying Family Medicaid, BadgerCare, and Healthy Start
- Strategies for assisting employers in continuing to provide coverage for employees, e.g., premium assistance
- Strategies to improve health outcomes for children, families, and pregnant women
- Proposed strategies for reaching agreement on approaches for budget neutrality

Out-of-Scope

- Discussion of possible changes to existing programs for children with disabilities and chronic health care needs, e.g., Katie Beckett and children's waiver programs
- SeniorCare, Family Care, and all other Medicaid services for the elderly, blind, and disabled are not included in this proposal
- Detailed analysis of waiver and budget neutrality requirements

Constraints and Assumptions

- The State strives to assure that, to the greatest degree possible, there will be no reduction in benefits for current enrollees of Family Medicaid, BadgerCare, or Healthy Start.
- Wisconsin is dedicated to streamlining and simplifying the eligibility process, thus, making it easier for families to enroll.
- To the extent possible, Wisconsin would like to use the flexibility available under the Deficit Reduction Act of 2005 (DRA) and other state plan amendment modifications to accomplish transformation of the existing Medicaid programs that support low-income children, families, and pregnant women.
- The State may submit waivers that would be granted by the U.S. Department of Health and Human Services Secretary under the authority of Section 1115 of the Social Security Act as needed to achieve the goals of BadgerCare Plus.
- The State is committed to achieving budget neutrality, as required by CMS.
- The State's existing SCHIP waiver is scheduled to lapse in March 2007. BadgerCare Plus will replace the BadgerCare waiver.
- The State will request an extension of the SCHIP waiver to cover the period of time between final approval and implementation of BadgerCare Plus and expiration of the current waiver.

BADGERCARE PLUS PROGRAM DESIGN

BadgerCare Plus will provide access to affordable, comprehensive health care coverage for all children in Wisconsin. The new program will be simple—simple to understand, simple to enroll in, and simple to administer. BadgerCare Plus will promote and support healthy living for low-income children, families, and pregnant women.

BadgerCare Plus has four strategic goals:

- ★ Cover all children
- ★ Provide coverage and enhanced benefits for pregnant women
- ★ Make the program simple
- ★ Promote prevention and healthy behaviors

The target expansion populations for BadgerCare Plus are:

1) All children (birth to age 19) with incomes above 185 percent of the FPL
2) Pregnant women with incomes between 185 and 300 percent of the FPL
3) Parents and caretaker relatives with incomes between 185 and 200 percent of the FPL
4) Caretaker relatives with incomes between 44 and 200 percent of the FPL
5) Parents with children in foster care with incomes up to 200 percent of the FPL
6) Youth (ages 18 through 20) aging out of foster care
7) Farmers and other self-employed parents with incomes up to 200 percent of the FPL, contingent upon depreciation calculations

Eligibility

The eligibility determination process under BadgerCare Plus will be simple. The following section describes Wisconsin's approach to consolidating Family Medicaid, BadgerCare, and Healthy Start. It also highlights how the program will be dramatically simplified and expanded to cover the targeted populations. Appendix A graphically depicts the proposed changes in policies in the areas discussed below.

Income Eligibility

The State proposes a simple gross income test with two deductions—1) the disregard of earnings for children under age 18; and 2) the deduction of child and family support payments made by a member of the applicant/recipient group to someone outside of the household. This proposed change will result in some parents and other relative caretakers who are currently enrolled in Medicaid having incomes that exceed 200 percent of the FPL. In order to lessen the impact on these adult caregivers, the State proposes to allow them to retain their coverage for a maximum of 18 months, regardless of family income. This is consistent with current COBRA coverage rules. The State estimates that this number is less than 1 percent of current enrollment, or about 2,700 parents/relative caretakers.

Under the Department's current policy, countable self-employment income is the family's gross income, minus all tax deductions, except for depreciation. This policy originated in the AFDC program and was continued under Family Medicaid and BadgerCare. A recent survey revealed that

about 14 percent of Wisconsin's farmers have no insurance coverage.[14] Of those that have insurance, farm families tend to pay more and get less. That is, their premiums and deductibles are high; benefits, especially preventive benefits, are minimal.[15]

The State proposes that certain farm and other self-employed families be allowed to buy into BadgerCare Plus. Wisconsin proposes a two-prong income test for this population, estimated at 13,200.

- Test family income (with depreciation included) against the 200 percent of the FPL income limit. If the income does not exceed the limit, the parent or other adult caretaker is eligible.
- If the family's income (with depreciation) is above 200 percent of the FPL, the income will be re-calculated deducting the depreciation. If the family's income, without depreciation, is below 200 percent of the FPL, the parents or other relative caretakers are eligible for the benchmark plan and will pay a premium equal to five percent of their income.

BadgerCare Plus will also be available to individuals between ages 18 and 20 years old who age out of foster care. Research indicates that youths in out-of-home care have higher than average health care needs, particularly mental health, family planning, and substance abuse needs. A 1998 University of Wisconsin-Madison study on youths in out-of-home care reported that only 21 percent of participating youths received needed mental health services in the year after leaving out-of-home care. Left untreated, these persistent health problems become barriers to further educational gains and meaningful employment. Current federal Medicaid law allows states to choose to cover this group under the optional coverage group added as a part of the Foster Care Independence Act. Eligibility for youth aging out of foster care will be phased in by age cohort. In the first year, youths age 19 or younger will be eligible. In the second year, youths age 20 or younger will be eligible.

Income Spenddown

The State proposes to allow pregnant women with incomes below 300 percent of the FPL to qualify for BadgerCare Plus. The test would examine whether incurred medical expenses over the prior six months equals the amount that family income exceeds 300 percent of the FPL. In addition, Wisconsin proposes to allow children (under age 19) who have insurance coverage or access and have catastrophic health care costs to spend down their incomes to 150 percent of the FPL. The family would be subject to premiums and all children would be enrolled in the Standard (Medicaid) Plan.

Presumptive Eligibility for Children

BadgerCare Plus will continue the current process of requiring individuals who want to apply for state-sponsored insurance to submit an application through the income maintenance system. This application may be submitted in person, over the telephone, through the mail, or via the Internet through the ACCESS web site. Information obtained through focus groups indicates the value of face-to-face interactions.

In addition, BadgerCare Plus will allow the determination of presumptive eligibility by qualified providers and other entities, e.g., Head Start, WIC, faith-based organizations, child care centers, schools, etc., for children under age 19 with incomes below 150 percent of the FPL and pregnant

[14] Wisconsin Farm Bureau Federation, July 2006.
[15] .Ibid.

women. Once a provider determines a child or pregnant woman eligible under presumptive eligibility, the child or pregnant woman will remain eligible for up to two months. ACCESS will be used to allow qualifying entities to perform the presumptive eligibility determination and certification.[16] Special training will be offered for those entities that elect to provide this service. In addition, the initial provider will be asked to help the family apply for BadgerCare Plus using ACCESS.

Crowd-Out

Wisconsin proposes a combination of direct and indirect policies to limit crowd out of private insurance. Since most crowd out policies interact with other policies, they are discussed in detail in respective sections. Appendix A highlights the interplay between crowd out and premium assistance. The direct policies include:

- Implementing "look back and look forward" health insurance access provisions. Individuals and families with current insurance coverage and access to employer-sponsored insurance, where the employer contributes 80 percent or more of the premium cost for individual or family coverage, who have had access to such a plan in the past twelve months, or who will be allowed to enroll in such a plan in the next three months, will not be eligible for BadgerCare Plus. In addition, those persons who have been covered by employer-subsidized insurance where the employer paid 80 percent or more of the individual or family plan premium are ineligible for three months. The provision applies to all children and non-pregnant adults with family incomes above 150 percent of the FPL.
- For pregnant women, the insurance access and coverage provisions do not apply. Rather, pregnant women with incomes above 200 percent of the FPL, but not greater than 300 percent of the FPL, will be eligible for the term of their pregnancy plus sixty days following the birth provided the enrollee retains any existing insurance coverage. There is no requirement for pregnant women with family incomes below 200 percent of the FPL to maintain insurance coverage.
- Expanding premium assistance (see *Premiums & Cost Sharing - Premium Assistance* section).
- Requiring monthly premiums as a condition of eligibility for non-pregnant, adult parents and other caretakers with family incomes above 150 percent of the FPL and for pregnant women and children under age 19 with family incomes above 200 percent of the FPL (see *Premiums & Cost Sharing* section).
- Offering a limited benefit package for children and pregnant women with incomes above 200 percent of the FPL and certain self-employed families with incomes below 200 percent of the FPL (see *Benefits* section).

The indirect policies consist of matching health insurance data sets; verification of access to and coverage under employer subsidized health insurance directly with employers; and monitoring and analyzing health insurance trends.

Verification

The State will eliminate the current employer verification process of health insurance access and coverage as well as earnings, which has proved problematic since its implementation in May 2004.

[16] Wisconsin is currently automating the presumptive eligibility determination and certification for pregnant women and for women under the Family Planning Waiver.

Employer failure to return the form often led to eligible families being denied coverage. The proposed process is described below.

- Eligibility workers will verify earnings using documentation (pay stubs, etc.) provided by the applicant or recipient for all adults applying for or receiving BadgerCare Plus.
- The eligibility worker will verify health insurance access and coverage directly with the employer when a family meets all of the other BadgerCare Plus eligibility requirements and has family income above 150 percent of the FPL. This verification will occur at application, at the annual review, when a new job is reported, and when the family's income increases to more than 150 percent of the FPL.
- To assist eligibility workers in this process, the State will establish a database that will include all employers of BadgerCare Plus adults. Each employer will supply the following on at least an annual basis.[17]
  - A contact name, address, e-mail address, and fax and telephone number
  - Whether the employer offers access to employer-subsidized health insurance for families where the employer pays 80 percent or more of the premium for any employee
  - If they offer 'affordable' coverage (see above), what type of employee is eligible for that type of coverage, including minimum number of hours, job title, job locations, etc.
  - When coverage is offered, information about the plan, including the open enrollment period, new employee waiting periods, etc.
- When determining BadgerCare Plus eligibility, the automated eligibility system will check on the employer information listed by BadgerCare Plus to determine if additional documentation is needed. Where the information indicates that the individual does not have access to affordable insurance, the individual (and family) will have passed the 'access' eligibility requirement.
- When the data has not been supplied by the employer or has not been updated, the employer will be sent a form asking for specific information about the employed adult. The employer must return the form in a timely fashion (as defined in law or rule). If the employer does not respond within the time period defined, the individual and family will have passed the 'access' requirement and the employer will be penalized financially, as is the case under current law. A specific financial penalty has not been defined, although it is currently $250 for every occurrence. The penalty will need to be sufficient to ensure a prompt response from employers.

In addition, both job and other income will be verified using automated data matches with current data, e.g., social security benefits, SSI, child support income, etc., when available. When those data matches are not available, applicants and recipients must verify all income.

Change and Renewal

Every year, participants in Family Medicaid, BadgerCare, and Healthy Start report more than 800,000 changes in incomes, household composition, and addresses. A recent analysis of the impact of these changes reveals that more than 26 percent of children in Medicaid and BadgerCare lost their eligibility and had a subsequent gap in their health care coverage. The average gap was almost five months with a median coverage gap of three months, significantly affecting continuity of

[17] The State hopes to offer employers the option of updating their information on a secure web site.

care. These unnecessary changes also result in additional costs to the State, health plans, and providers.

Similar to the simplified change reporting policy currently in place in the State's FoodShare (Food Stamp) Program, Wisconsin proposes to only require families to report changes that would end their eligibility for BadgerCare Plus. Routine data matches will continue to occur. This change will help streamline and simplify the eligibility process, make BadgerCare Plus easier to understand, and potentially further reduce Wisconsin's Food Stamp payment accuracy error rate. This change will also reduce the program's administrative cost.

With regard to renewals, the State proposes to review and re-determine eligibility for BadgerCare Plus annually. BadgerCare Plus will include a web-based ACCESS Renewal Tool and preprinted renewals thus eliminating unnecessary gaps in coverage that occur when families are unable to complete the renewal process in a timely manner.

Backdating

Backdating allows applicants to receive benefits for a period before the date that he or she applies for medical assistance. Wisconsin proposes to allow backdating for up to three months for children, parents, and caretaker relatives with incomes below 150 percent of the FPL. This policy is consistent with current efforts that allow enrollees in Family Medicaid to receive benefits for up to three months before the date that he/she applies. Recent data indicates that about 26 percent of children and adults applying for Medicaid are eligible for backdated coverage.

A recent study by MarketWatch supports this policy. The study found that of the 1.458 million Americans that filed for bankruptcy in 2001, about half cited medical causes. Among those whose illnesses led to bankruptcy, out-of-pocket costs averaged $11,854 since the start of illness; 75.7 percent had insurance at the onset of illness. Medical debtors were 42 percent more likely than other debtors to experience lapses in coverage.[18]

Benefits

As indicated in Appendix B, BadgerCare Plus will have two benefit plans for different coverage groups. Children; parents and caretaker relatives; youths aging out of foster care, and pregnant women with incomes up to 200 percent of the FPL will be enrolled in the existing Medicaid benefit package, now called the Standard Plan. Children and pregnant women with incomes above 200 percent of the FPL and self-employed parents with incomes under 200 percent of the FPL (as a result of the depreciation test) will be enrolled in the Benchmark Plan.

Standard Plan

Wisconsin Medicaid covers all mandatory and optional health care services for which federal matching funds are available. Covered services include: prescription drugs; physician services; inpatient and outpatient hospital services; intermediate care facility services; laboratory and x-ray services; medical supplies and equipment; dental and vision services; Early, Periodic, Screening, Diagnosis, and Treatment services; mental health and alcohol and drug addiction (AODA) services; day treatment services; nursing services; personal care services; physical, occupational, and

[18] Himmelstein, David, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler. "MarketWatch: Illness And Injury As Contributors To Bankruptcy." *Health Affairs: The Policy Journal of the Health Sphere.* 2 February 2005.

speech therapy; and transportation to obtain medical care. The Standard Plan will maintain this level of coverage.

Individuals enrolled in the Standard Plan will receive dental services as currently offered via fee-for-service except in the four counties where dental benefits are delivered through HMOs. Wisconsin is dedicated to significantly increasing access to dental care, an issue raised repeatedly in the BadgerCare Plus town hall meetings and in the focus groups. To that end, the State will issue a Request for Information (RFI) to solicit interest among health care providers for designing and managing a service delivery system for dental benefits for BadgerCare Plus participants. The explicit goal of this process is to identify a service delivery model that is superior to the current model in terms of dental access. In addition, the new system will need to build on or expand current innovative local partnerships that are meeting the needs of Wisconsin residents. Innovative regional and local solutions will also be considered.

In the event responses to the RFI do not meet the stated goal, the State proposes to develop two pilot initiatives to determine a reasonable, long-term solution to increasing access to dental services. One pilot initiative will be a pay-for-performance (P4P) effort targeting fee-for-service providers in a selected geographic region in the state. The framework for this effort includes development of a state-sponsored network of private providers with perhaps "signing bonuses" for joining the network and rewards scaled to providers that see the largest number of BadgerCare Plus enrollees. The second pilot initiative will explore the feasibility of a public health model for dental services, building on the work of Wisconsin's federally qualified health centers, existing community partnerships, and other cost-effective providers.

Should the pilots be necessary, each will be evaluated to determine which approach is the most effective in significantly increasing the availability of quality dental services for low-income children and families. In addition, the State will examine the results of the current P4P initiative to increase access to dental services for Family Medicaid enrollees in the four counties where dental services are delivered through HMOs. The outcome of the evaluations will determine the service delivery model for dental services for BadgerCare Plus participants in the future.

In addition to funds currently available for dental services, the State will set-aside $8.8 million in additional funding to either help fund the new system that will be developed as a result of the RFI or to fund the two pilot initiatives.

Current participants in Family Medicaid, BadgerCare, and Healthy Start will continue to have access to the full range of benefits in the Standard Plan. Children, pregnant women, and parents/relative caregivers with incomes below 200 percent of the FPL, and youth aging out of foster care will also have access to the Standard Plan.

Benchmark Plan

A key component of BadgerCare Plus is the comprehensive benchmark plan adapted from Wisconsin's largest commercial, low-cost health care plan which is provided by United Healthcare. The benchmark plan will be available to children and pregnant women with incomes above 200 percent of the FPL. Certain farmers and other self-employed parents will also be enrolled in the Benchmark Plan.

Four benefits were added to the commercial benchmark plan to ensure that the plan meets the needs of the targeted populations. These are: prescription drugs, early childhood development services, dental services, and mental health/alcohol and drug addition services. In addition, the plan includes two preventive benefits targeted to pregnant women.

The Benchmark Plan will include a limited prescription drug benefit. Children, pregnant women, and certain self-employed parents will be offered all MA preferred generic drugs at a minimum co-pay of $5.00 and allowed to utilize BadgerRx Gold, an existing statewide prescription drug purchasing program, to purchase all other drugs at a discount.

Similar to the majority of commercial plans, United Healthcare covers all basic and routine physician office visits, immunizations, and laboratory services, including well-child checkups. To enrich these benefits, the benchmark plan will include a bundled set of early childhood development services for children under age six. These benefits are defined as: developmental surveillance, screening and assessment services; developmentally-based health promotion and education; developmentally-based interventions; and care coordination.

Like many commercial plans, United Healthcare does not cover preventive, basic, or major dental care services. Preventive and basic services were added to the base plan with limitations on the number of services and a capped amount of benefits per year, similar to the dental plan available to state employees through selected HMOs or enrollment in a separate dental plan. Dental benefits under the Benchmark Plan will be delivered though Wisconsin's current hybrid system of fee-for-service for the majority of the state and HMOs in four counties. The State anticipates that the delivery mechanism for dental service will change pending the efforts described in the benefits section.

United Healthcare provides very limited coverage for mental health/AODA services. While Governor Doyle and the Department are committed to moving to mental health parity, research indicates that adverse selection—the tendency of health insurance plans offering the most comprehensive coverage to attract those individuals most in need of care—is a significant problem with regard to mental health benefits and is difficult to control unless all available plans offer similar benefits. The Benchmark Plan will include mental health and AODA benefits equivalent to the coverage provided to state employees. These benefits will be linked to the state employee health care plan so that benefits remain consistent between the two plans over time.

Finally, the Benchmark Plan will provide Prenatal Care Coordination benefits for pregnant women at high risk of poor birth outcomes with incomes above 200 percent of the FPL, consistent with the Department's Healthy Birth Outcomes Initiative. In addition, the Benchmark Plan includes two new preventive services targeted to this population—smoking cessation and preventive mental health counseling.

The enhanced smoking cessation benefit for pregnant women adds nicotine gum, group counseling, and telephone counseling to the current Medicaid benefit allowing physicians to customize treatments for each individual. The gum and the patch will be available via prescription or over-the-counter.

In addition, pregnant women with incomes above 200 percent of the FPL at high risk for poor birth outcomes will have access to mental health and substance abuse counseling by a trained clinician as part of the Prenatal Care Coordination benefit. This preventive benefit will be further targeted to high risk pregnant women at risk for depression or related mental health or substance abuse problems.

Healthy Living

Another key component of BadgerCare Plus is the development of both individual and system-level incentives to promote and support healthy behaviors and improved health outcomes. Wisconsin believes that the only way to address rising health care costs in the long-term is to help individuals get and stay healthy.

The State's system level incentives will build on current efforts to improve the quality of care. Currently, fourteen HMOs are participating in the Department's pay-for-performance initiative (P4P). Under P4P, health plans work closely with the Department to develop strategies for addressing specific health issues, e.g., smoking, lead poisoning, and utilization of dental services. These discussions include the establishment of measurable target goals with incentive payments dependent on the percentage of the goal achieved.

Wisconsin is proposing to target five areas for system level and individual incentives under BadgerCare Plus. These are:

- Increases in well-child visits and childhood immunization rates
- Reductions in smoking among enrollees
- Reductions in childhood obesity
- Reductions in infant mortality, especially among minority populations
- Reductions in inappropriate use of emergency rooms

In addition, the State will build on successful efforts by several HMOs to encourage and support healthier behaviors by enrollees. At the state level, a non-binding member agreement will be developed and implemented either as part of the eligibility process or the enrollment process. The agreement will outline broad responsibilities for individuals such as "I will make sure that my children get all of their shots on time and take my children to well-child check-ups," "I will keep and be on time for scheduled appointments," "I will only use the emergency room for emergencies," "I will try to quit smoking." It will also include member rights, such as "I have the right to pick my medical home," "I have the right to decide things about my health care and that of my children," "When I decide to quit smoking, my health plan will help me," "I will be treated fairly and with respect." While the agreement is non-binding, Wisconsin believes that it provides a clear message that individuals play a critical role in their own health.

The State will establish a workgroup to develop guidelines and parameters for the "individual incentive plans." At a minimum, each plan will be required to include specific, measurable goals; a description of current efforts; and any relevant outcomes from these efforts. The plans will be evaluated by an internal group and monitored for performance.

The State will also develop strategies for helping individuals learn how to better manage their health. For example, the State is currently working with an advocacy organization to explore

development of a simple curriculum for BadgerCare Plus consumers that could be used in a wide array of settings with diverse trainers. The curriculum will include topics such as "when to use the emergency room," "why is it important to keep and be on time for my appointments," "why is it important to take my child for check-ups when they aren't sick," "why should I quit smoking and how can my health plan help me do that," and "the importance of exercise."

Since promoting healthy behaviors among the Medicaid population is a relative new domain, Wisconsin will consider allowing HMOs to do small pilot programs to test effectiveness. For example, one HMO may explore establishing individual cash accounts, similar to Florida's proposal, and allow individuals to redeem them only at one or two specific stores in exchange for meeting targeted goals for behavior changes such as making and keeping all primary care appointments and for participating in a smoking cessation program. Another HMO may test whether providing fresh produce coupons influences individual nutrition and subsequent weight loss. The same HMO may experiment in a different community with establishing small self-support groups that meet in individual homes or other convenient locations to test a health curriculum on exercise and weight loss and to see whether support groups assist individuals in losing weight. The pilot projects will be subject to external evaluation in partnership with the University of Wisconsin Population Health Institute.

Premiums & Cost Sharing

There are four distinct groups that will be required to pay premiums under BadgerCare Plus. Appendix C highlights the groups subject to premiums.

1) Children with incomes above 200 percent of the FPL
2) Parents with incomes between 150 and 200 percent of the FPL
3) Pregnant women with incomes above 200 percent of the FPL
4) Certain self-employed parents with incomes below 200 percent of the FPL

The premium and cost-sharing structure is based on the following principles.

- Premium amounts are based on a sliding income scale; were calculated using a polynomial equation; and are based on the average per member per month cost.
- A minimum premium is required for all individuals subject to the premium requirement.
- A cap of five percent of family income has been determined for non-pregnant adults.
- Premium rate bands, caps, and minimums are still being discussed.
- Co-payments will be required for certain services in the Benchmark Plan for pregnant women and children with incomes above 200 percent of the FPL, and certain adult parent/caretakers who are farmers (or otherwise self-employed) with family income below 200 percent of the FPL.
- Nominal co-payments, which exist under current law, will be assessed to participants in the Standard Plan.
- Prevention services, e.g., immunizations, well-child visits, smoking cessation, pre-natal care, etc., are not subject to cost-sharing.

Wisconsin proposes to apply the 5 percent cost-sharing cap required under the DRA in aggregate, across the eligible population below 200 percent of the FPL. This approach provides the most

flexibility to meet program objectives, i.e., premiums and co-payments may be charged, entails the fewest system changes, and models the current system for participants and providers.

Cost sharing under BadgerCare Plus is divided into two distinct groups—1) individuals with incomes below 200 percent of the FPL and enrolled in the Standard Plan will have the same nominal co-payments as in the current Family Medicaid, BadgerCare, and Healthy Start programs. 2) Individuals with incomes above 200 percent of the FPL will have co-payments for certain benefits in the Benchmark Plan (see Appendix B for specific co-pays). Wisconsin proposes to institute a co-payment for the inappropriate use of emergency rooms for the expansion population. This policy would better support personal responsibility and encourage individuals to have a medical home. The State will work with HMOs to develop strategies for determining appropriate use, especially in rural areas of the state where urgent care centers do not exist and local hospital emergency rooms serve this function. Appropriate use of emergency rooms will be included in the State's "Healthy Living" curriculum (see *Benefits – Healthy Living* section). Information will also be provided during enrollment and at each renewal. The State will also work closely with HMOs and the provider community to determine consequences for failure to make co-payments.

Premium Assistance

Wisconsin's Health Insurance Premium Payment (HIPP) program helps low-income families pay the employee contribution of their employee-sponsored insurance. The HIPP program is currently integrated within BadgerCare and pays the family's share of the monthly premium, co-insurance, and deductibles associated with the family health plan along with any BadgerCare covered services not included in the family health plan through fee-for-service (wrap around).

BadgerCare Plus will significantly increase enrollment in HIPP. Appendix A highlights new areas of coverage. These include providing premium assistance for:

- Children and parents with incomes below 150 percent of the FPL even when the employer pays 80 percent or more of the premium when it is cost effective to do so
- Pregnant women with incomes up to 300 percent of the FPL when the employer pays 80 percent or more of the premium (wrap around benefits)
- Children with incomes between 200-300 percent of the FPL when it is cost effective to do so

The State also proposes to expand HIPP in the following ways:

- Farm and other self-employed families will be covered under HIPP
- Self-funded insurance plans will be allowed to participate in HIPP
- Minimum employer contribution requirements will be eliminated and employer-sponsored insurance (ESI) will be based solely on cost effectiveness
- Access to HIPP coverage will be allowed even if single or 'plus one' coverage is the only coverage offered by an employer

Wisconsin's approach to premium assistance can be summarized in three questions.

1) Is the individual who is eligible for BadgerCare Plus, also eligible for health insurance coverage from his or her employer for which the employer pays less than 80 percent of the premium?

2) If yes, is the actual health insurance benefit offered by the employer close enough to those offered by BadgerCare Plus to justify looking at premium assistance for the individual to enroll in the employer-sponsored plan?
3) If yes, is it more expensive to enroll the individual in the fully-funded BadgerCare Plus program than to "use" premium assistance and spend the amount required by the employer to enroll the individual in the employer-sponsored plan? Or, compare the cost of enrollment in fully-funded BadgerCare Plus with the sum or premium assistance plus the cost of wrap-around services needed to equalize the two sets of benefits. If yes, then premium assistance should be used.

This analysis would be done on a per person basis. Thus, in any given family, the answer to question three might be "no" for the child, i.e., it is cheaper to enroll the child in BadgerCare Plus than to use premium assistance to "buy" the child into the employer-sponsored plan, while the answer may be "yes" for the parent, i.e., it is cheaper to use premium assistance to "buy" the parent into the employer-sponsored plan versus enrolling the parent in BadgerCare Plus. The answers could also be reversed for the child and parent, or "no" for both, or "yes" for both.

In addition, the BadgerCare Plus initiative is designed to maximize employer-sponsored insurance whenever it is cost effective to do so. State and federal subsidized premium assistance is one strategy for meeting this goal and reducing the impact of crowd out. Generally, the cost effectiveness test must demonstrate that the cost of covering an eligible family or individual under private insurance is no more than the cost of covering the family or individual under Medicaid.

BadgerCare Plus will maintain Wisconsin's current policy to determine cost effectiveness. That is, for individuals and families with incomes under 200 percent of the FPL, the State will identify the cost of wrapping around the Medicaid services with the employer-sponsored plan and then determine cost effectiveness of "buy-in" on that calculation of cost comparability.

For individuals and families with incomes between 200 and 300 percent of the FPL, if the employer plan has benefits equal to the BadgerCare Plus Benchmark Plan, the State will "buy-in" to the employer plan when it is cost effective to do so. In this instance, the State will not look at the comparability of the cost sharing, e.g., amounts of co-pays. Rather, the State will determine the cost effectiveness based on comparability of the covered benefits.

Restrictive Re-Enrollment

To the extent possible**,** BadgerCare Plus is designed to mirror commercial health insurance plans. As such, the public has a reasonable expectation that individuals who can afford to do so pay their fair share. Wisconsin proposes to maintain current policy whereby enrollees with incomes above 150 percent of the FPL who fail to pay their monthly premium are terminated and may not re-enroll for six months. This provision continues a current feature of BadgerCare. The State will also maintain the flexibility of local agencies and the Department to consider individual/family circumstances in determining whether good cause exists in a specific case.

Service Delivery

Managed care has been extremely successful in Wisconsin. BadgerCare Plus will build on this success by enrolling all participants in managed care within two years. To move to statewide coverage, the Department will provide strategic incentives to participating health plans to expand

their service areas and lift self-imposed enrollment caps when it is cost effective to do so. Eight regions within the state have been targeted for expansion. Full participation in these regions will represent an increase in HMO enrollment of more than 50 percent of the current Family Medicaid, BadgerCare, and Healthy Start population.

Until sufficient managed care capacity is available statewide, some BadgerCare Plus participants not enrolled in an HMO will access services via fee-for-service. The exception to this policy is dental care which is discussed in the benefits section.

Health Needs Assessment

In 2001, the Department developed and implemented an enrollee health risk assessment tool—New Enrollee Health Needs Assessment survey—in partnership with HMOs and other stakeholders. The survey is administered by enrollment brokers by phone to all new enrollees on a voluntary basis and can be completed in about eight minutes. Data from the survey is provided electronically to the HMO to facilitate rapid outreach to the enrollee and to provide needed linkages to services. HMOs find the information very helpful and have requested the addition of several questions since initial implementation.

The State proposes to include the health risk assessment tool as a part of the enrollment process for all BadgerCare Plus participants. The tool will be incorporated into the on-line ACCESS application and also included as a part of mail-in applications and in-person applications. Participation in the survey will remain voluntary.

Waiver Considerations

Wisconsin will work closely with CMS to determine the components of BadgerCare Plus that can be implemented through DRA and the Medicaid and SCHIP State Plan amendment process and which components will require Section 1115 waivers of federal law or regulation.

The State anticipates renewing the BadgerCare waiver that allows Wisconsin to claim for adults with incomes between 100 percent and 200 percent of the FPL at the SCHIP rate. The State will request an extension of the current waiver to cover the time between final implementation of BadgerCare Plus and expiration of the BadgerCare waiver in March 2007.

Funding and Budget Neutrality

The financial analysis for determining the fiscal impact to the State of the proposed BadgerCare Plus Program was developed using a sophisticated financial model developed by the Department in partnership with PricewaterhouseCoopers, its contracted consulting actuary.

This analytical tool allowed the Department to simultaneously model up to four different benchmark benefit plans to determine the financial impact on the state budget and establish projected take-up rates for newly eligible individuals based on multiple assumptions about monthly member premiums. The financial model also helped identify the impact that co-payments may have on member utilization of services, and calculated the associated financial savings. In addition, the model estimated potential savings associated with assumptions about moving individuals from fee-for-service into managed care. Finally, it quickly, consistently, and uniformly displayed the impact of various assumptions concerning health care cost trends, managed care discounts, and cost/utilization variables across individuals at different income levels.

Using this new tool, the State is confident that BadgerCare Plus can be funded entirely out of savings generated within the new program and through cost-sharing contributions by participants. The State proposes that budget neutrality for BadgerCare Plus be established on a per person per month basis. (See Appendix D for projected costs and savings.)

In addition, the State estimates more than $12 million annually in administrative savings at the local level resulting from eligibility simplification and streamlining. These savings are not reflected in Appendix D.

Reinvestment Plan

The State anticipates generating one-time savings of approximately $15.9 million over the biennium (SFY 07-09). These savings will be re-invested in BadgerCare Plus over the next two years to support critical elements of the new program. These elements were identified through discussions with the BadgerCare Plus Advisors Group, comments at the town hall meetings, and responses to questions during the focus groups. These elements are highlighted in the following table.

BadgerCare Plus Re-Investment Plan: 07-09 Biennium ($ million)		
	GPR	***All Funds***
Healthy Living P4P Initiatives	$ 1.44	$ 3.5
Dental Access Innovation	$ 3.64	$ 8.8
HMO Expansion Incentives	$ .83	$ 2.0
Other Innovative Partnerships	$ .17	$ .4
Marketing/Outreach	$ .25	$ .5
Mini-grants to schools, faith-based organizations, etc. for outreach and enrollment assistance	$ .10	$ .2
Benefit Counselors/Navigators	$ .10	$ .2
Healthy Living curriculum development, training, and materials	$ .05	$ .1
Evaluation	$ .07	$ .2
TOTAL	**$ 6.6**	**$15.9***

*The total available for re-investment represents savings from greater usage of managed care, dramatic simplification, changes in program design, and maximization of federal funding.

PROJECT APPROACH

Wisconsin Governor Jim Doyle announced the BadgerCare Plus initiative in his State-of-the-State address in January 2006 and charged the Department of Health and Family Services with designing a comprehensive health care program that would serve all Wisconsin children. An internal Steering Committee was formed in February with numerous workgroups involved in developing option papers on a wide range of issues. Regular meetings of the BadgerCare Plus Steering Committee have been held throughout the spring and summer resulting in this final proposal.

In addition, all Steering Committee recommendations have been discussed with the BadgerCare Plus Advisors Group (see *Public Involvement—Advisors Group* section). Their comments and suggestions have been incorporated in this proposal.

The Department has identified a team of key leaders to work closely with CMS to gain approval to implement BadgerCare Plus no later than January 2008. This team will also be responsible for working closely with Wisconsin's Senate and Assembly to make the budget and legislative changes required for implementation. Post-implementation plans include an independent evaluation of the program.

PUBLIC INVOLVEMENT

Since the announcement of the BadgerCare Plus initiative in January, the State has worked diligently to inform Wisconsin citizens about the proposal as well as seek input into its design. This outreach is described in the following sections.

BadgerCare Plus Advisors Group

The BadgerCare Plus Advisors Group is responsible for providing guidance and advice to the State on all policy and program design issues. The group met six times during the development of BadgerCare Plus to review and discuss recommendations from the internal Steering Committee and offer suggestions for improvements. Each of these two-hour sessions was a public meeting. The Advisors Group includes representatives from business, health plans, providers, public health, farmers, Native American tribes, the State Legislature, faith-based organizations, county government, children's advocacy groups, and the University of Wisconsin.

The Advisors Group will continue to work with the Department through implementation. Current members are:

- Bevan Baker, City of Milwaukee Health Department
- Melissa Duffy, Wisconsin Federation of Cooperatives
- Donna Friedsam, University of Wisconsin Population Health Institute
- Sabrina Gentile, Wisconsin Farm Bureau Federation
- Representative Curt Gielow and Representative Jon Richards, Wisconsin State Assembly
- Jason Helgerson, Department of Health and Family Services
- Michael Jacob, Covering Kids and Families—Wisconsin
- Nyree Kedrowski and Lori Pidgeon, Ho-Chunk Nation
- Ed Kamin, Kenosha County Department of Human Services
- Dr. John Meurer and Dr. Glenn Flores, Medical College of Wisconsin
- Senator Mark Miller and Senator Dan Kapanke, Wisconsin State Senate
- Father Thomas Mueller, St. Cyril and Methodist Orthodox Church, Milwaukee
- Paul Nannis, Aurora Health Care
- Jon Peacock, Wisconsin Council on Children and Families
- Bobby Peterson, Advocacy & Benefits Counseling (ABC) for Health, Inc
- David Riemer, Wisconsin Health Project
- Bill Smith, National Federation of Independent Business
- Dr. Susan Turney, Wisconsin Medical Society
- Nancy Wenzel, Wisconsin Association of Health Plans

Focus Groups

Wisconsin held eight focus group discussions to identify problems with current programs, suggest improvements, and provide feedback on concepts and strategies proposed for BadgerCare Plus. One group was composed of BadgerCare and Medicaid providers from throughout Wisconsin. The remaining seven groups, with representatives from thirteen communities across the state, were composed of low-income families, both individuals currently enrolled in Family Medicaid, BadgerCare, and Healthy Start and parents without current health insurance coverage. Each group included 15-20 individuals and lasted an average of one and one-half hours. Each participant received a stipend of $20.00 to off-set transportation and/or child care expenses.

The provider group included representatives from HMOs and physicians. Responses revealed that providers remain concerned about 'no-shows,' that reimbursement rates are too low, and that Medicaid patients are often difficult to treat due to their chaotic lives. A key theme among the group was the need for patients to have a primary care physician. A second theme was the need to help patients understand the need to get and stay healthy and that incentives might be one strategy for achieving this goal. The lack of access to dental care and mental health services was a third theme of the discussion.

Findings from the participant groups indicated a preference for submitting applications by mail or over the telephone; some individuals expressed appreciation for face-to-face appointments because it allows them an opportunity to ask questions and get immediate answers. As expected, key reasons for the lack of health insurance were high premiums and/or employers not offering insurance. When asked about their willingness to participate in smoking cessation or weight management programs, the majority of participants expressed an interest and suggested that state health programs partner with local gyms, the YWCA, or fitness centers to encourage individuals to use these benefits.

As noted earlier, each group acknowledged the importance of dental coverage and the continuing difficulty of finding a dentist who would accept their Medicaid card. One participant noted that in her community, individuals were placed on waiting lists for up to two years for routine dental care. Many participants said that access to dental care would not be an issue if they had private insurance.

Finally, several participants in each group felt that they were treated differently in health care settings than individuals with private insurance. Other findings include: satisfaction with Wisconsin's existing programs, concern that single adults would not be included in BadgerCare Plus, and concern that increased co-payments would have a negative impact on their family. See Appendix E for specific focus group questions.

Medical Assistance Advisory Committee

The Medical Assistance Advisory Committee (MAAC) will be asked to provide comments on the proposal and the program design for BadgerCare Plus.

Native American Consultation

Wisconsin Executive Order #39, issued in February 2004, affirms the government-to-government relationship between the State of Wisconsin and the eleven American Indian tribal governments

located within the State of Wisconsin. The "Department of Health and Family Services Policy on Consultation with Wisconsin's Indian Tribes," developed by consensus with the Wisconsin tribes, formalizes the tribal-state relationship. Wisconsin has sent an invitation to all Wisconsin tribes to participate on the BadgerCare Plus Advisors Group and two tribal representatives are participating.

Town Hall Meetings

Governor Doyle, Lieutenant Governor Barbara Lawton, and Secretary Helene Nelson hosted twenty town hall meetings across the state throughout the planning process to discuss the new program, gather comments about existing programs, and obtain input from interested parties. Each town hall meeting included current Medicaid/BadgerCare participants, health care providers, county staff, advocates, reporters, and others. BadgerCare Plus cards with the Initiative's e-mail address were distributed at each meeting with encouragement to participants to send written comments. Two or three e-mails are received daily via this site. The town hall meetings were developed in partnership with the Wisconsin Council on Children and Families and ABC for Health, Inc.[19] The list of sites and presenters follows.

January 18th	Marshfield	Secretary Nelson
January 19th	Rhinelander	Secretary Nelson
January 20th	Baraboo	Secretary Nelson
January 30th	Beloit	Secretary Nelson
May 2nd	Green Bay	Secretary Nelson and Jason Helgerson
June 14th	Wausau	Governor Doyle and Secretary Nelson
June 21st	Racine	Governor Doyle and Jason Helgerson
July 20th	Eau Claire	Governor Doyle and Secretary Nelson
July 20th	Superior	Governor Doyle and Jason Helgerson
July 24th	Beloit	Governor Doyle and Jason Helgerson
July 25th	Prairie Du Chien	Governor Doyle and Secretary Nelson
July 31st	Shawano	Lt. Governor Lawton and Linda McCart
August 1st	Jefferson	Secretary Nelson
August 4th	Portage	Secretary Nelson
August 8th	Oshkosh	Secretary Nelson
August 14th	Milwaukee, Northside	Governor Doyle and Secretary Nelson

[19] The Wisconsin Council on Children and Families is a nonprofit, multi-issue child and family advocacy organization that promotes the well-being of children and families in Wisconsin by advocating for effective and efficient health, education, and human service delivery systems. The Council's statewide membership is comprised of individuals; businesses and community groups; and professional, private, and public agencies. ABC for Health, Inc. is a Wisconsin-based, nonprofit, public interest law firm dedicated to ensuring access to health care and coverage for children and families. Through the development of local and regional Health Watch coalitions, ABC for Health, Inc. has gained expertise in working with local stakeholders to develop statewide strategies to address barriers to both health care and coverage.

August 15th	Madison	Lt. Governor Lawton and Secretary Nelson
August 23rd	Ashland	Secretary Nelson
August 24th	Antigo	Lt. Governor Lawton and Secretary Nelson
September 5th	Milwaukee, Southside	Lt. Governor Lawton and Secretary Nelson

Legislative Briefings

In addition to legislative participation on the BadgerCare Plus Advisors Group, several legislators participated in the town hall meetings. As development of the proposal continues, the Department will provide briefings for members of the Wisconsin State Legislature.

The Department will also arrange individual briefings for interested legislators and/or their staff and the Legislative leadership. Special outreach will be conducted for legislators on key committees, including the Joint Committee on Finance; Senate Committee on Health, Children, Families, Aging and Long Term Care; the Assembly Committee on Health; the Assembly Committee on Children and Families; and the Assembly Committee on Medicaid Reform.

Web Sites

Another key component of Wisconsin's outreach and communication strategy is both and internal and external web sites—http://dhfs.wisconsin.gov/badgercareplus/. Both sites include a brief description of BadgerCare Plus; a calendar of events; a list of frequently asked questions from the town hall meetings; the initial concept paper; the Advisory Board meetings, agendas, and briefing materials; information about the uninsured in Wisconsin; and an overview of Wisconsin's Medicaid program. The Department's internal web site also includes access to each of the option/decision papers and summary documents. The final proposal will be available on both sites.

Income Maintenance Advisory Committee (IMAC)

The Department consults regularly with a group of managers from county and tribal governments who are experts in the determination and certification of benefits for Medicaid, BadgerCare, Food Stamps, and Temporary Assistance for Needy Families (TANF) programs. These managers are appointed by the Wisconsin County Human Services Association and meet monthly with Department staff and managers. The BadgerCare Plus eligibility policy and process changes have been described and discussed with the IMAC and changes recommended as a result of these discussions have been incorporated into the program design.

APPENDIX A - ELIGIBILITY CRITERIA

Premium Assistance and Crowd out Provisions

As of August 9, 2006

	children and parents 0-150% FPL		children and parents 150-200% FPL (BadgerCare)		children 200-300% FPL		children above 300% FPL		pregnant women 200% to 300% FPL	
	now	**BC+**	**now**	**BC+**	**now**	**BC+**	**now**	**BC+**	**now**	**BC+**
Do we collect other health insurance information? How much?	0-6 No 6-18 Yes	yes	0-6 No 6-18 Yes	yes	not covered	yes	not covered	yes	not covered	yes, require MOE
Do we coordinate benefits if other health insurance is available?	0-6 No 6-18 Yes	yes	0-6 No 6-18 Yes	wrap around	not covered	no	not covered	no	not covered	wrap around
Is a person <u>eligible</u> if employer pays 80% or more for health insurance premium?	0-6 Yes 6-18 No	yes	0-6 Yes 6-18 No	no	not covered	no	not covered	no	not covered	yes, require MOE
Do other crowd out provisions apply?	0-6 No 6-18 Yes	no	0-6 No 6-18 Yes	yes	not covered	yes	not covered	yes	not covered	no
Are there cost sharing requirements?	no	no	yes	yes, sliding scale premiums	not covered	yes, sliding scale premiums	not covered	full PMPM HMO rate	not covered	yes
Will we provide premium assistance if it is cost effective?	no	yes	yes	yes	not covered	yes	not covered	no	not covered	yes, wrap around
Will we provide premium assistance even if employer pays 80% or more of the premium cost?	no	yes	no	not eligible	not covered	not eligible	not covered	n/a pay full cost	not covered	yes, wrap around

MOE = Maintenance of Effort

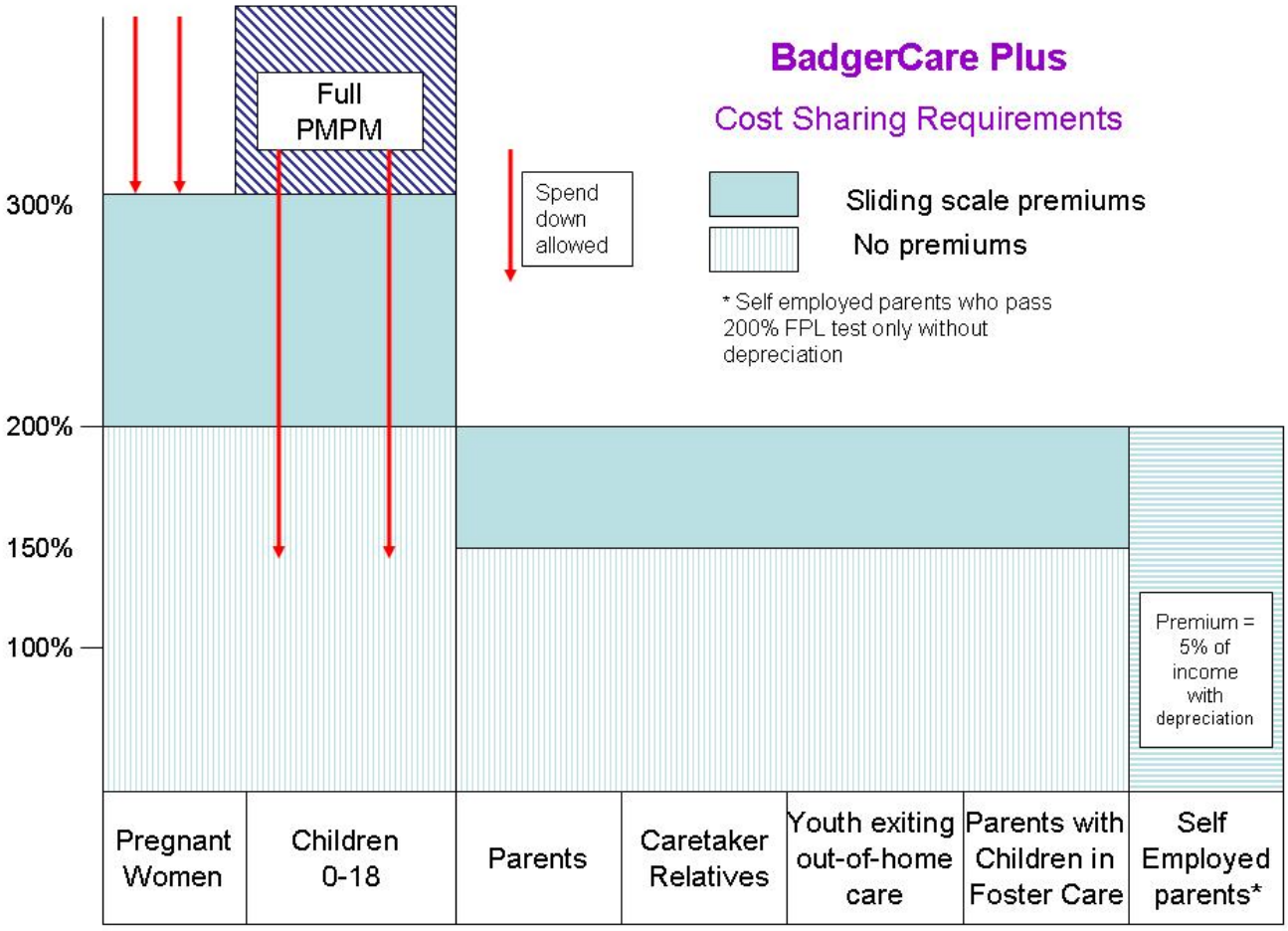
APPENDIX B - BENEFITS & COST SHARING

Services	Below 200% FPL Standard Plan * (Medicaid benefits*)	Above 200% FPL Benchmark Plan *
Prescription Drugs	Formulary; generic drugs--$.50 co-pay	MA preferred generic drugs at $5 co-pay and BadgerRx discounts
Physician Visits	Full coverage, including second opinion on elective surgery; $1 co-pay	Full coverage, one routine physical exam per year; $15 co-pay
Inpatient Hospital	Full coverage, prior authorization for transplants, AIDS acute care, etc.; $3 co-ay	Full coverage as medically necessary; $100 co-pay for med/surgical; $50 co-pay for Psych
Outpatient Hospital	Full coverage; home health covered as needed with physician approval every 62 days; $3 co-pay for use of ER	Lab, x-ray, mammography fully covered; home health limited to 60 visits/year; $15 co-pay for out-patient services; $75 co-pay for non-emergency use of ER
Nursing Home	Full coverage	Skilled nursing services limited to 30 days/year; inpatient rehabilitation limited to 60 days/year.
Physical, Occupation, Speech Therapy	Full coverage; $1 co-pay	20 visits per therapy discipline, 36 visits for cardiac rehab; $15 co-pay/visit
Durable Medical Equipment	Full coverage; $.50 co-pay	Benefits limited to $2,500/year $5 co-pay
Mental Health and AODA	Full coverage$1 co-pay	Linked to state employee plan; outpatient services covered up to $1,800/year, transitional up to $2,700/year, AODA services up to $7,000/year; $15 co-pay/visit
Transportation	Emergency and non-emergency to doctor/hospital; $1 co-pay	Emergency transportation covered as medically necessary; no coverage for non-emergency; $5 co-pay
Health Screenings for Children	Children up to age 21 fully covered	Early childhood developmental services for children under age 6.
Dental	Preventive and basic services; $1 co-pay	Preventive and basic services only for pregnant women and children under 19; covers 50% of allowable charges; annual deductible of $200; maximum benefit of $750; also includes accidental injury and diagnosis & treatment of temporamandibular disorders (TMJ); $15 co-pay/visit
Vision	Eye exams, optometry, ophthalmology; $1 co-pay	1 refractive eye exam every 2 years; $15 co-pay/visit
Smoking cessation	Full coverage	Pregnant women only
PNCC	Pregnant women at high risk	Pregnant women at high risk only

*co-pays for fee-for-service only

* based on initial financial model estimates

APPENDIX C - PREMIUM STRUCTURE



APPENDIX D - ESTIMATED FUNDING

Budget Neutrality			
	SFY 08	**SFY 09**	**BIENNIUM**
Benefit Cost	$ 9.1 million	$ 37.8 million	$ 46.9 million
State Admin Cost	$ .8 million	$ .0 million*	$ .8 million
Total Cost	**$ 9.9 million**	**$ 37.8 million**	**$ 47.7 million**
Benefit Savings	$ 17.4 million	$ 37.6 million	$ 55.0 million
State Admin Savings	$ 1.3 million	$ 2.5 million	$ 3.8 million
Total Savings	**$ 18.6 million**	**$ 40.1 million**	**$ 58.8 million**
NET COSTS: ALL FUNDS	**($ 8.7 million)**	**($ 2.3 million)**	**($ 11.0 million**
NET COSTS: GPR	**($ 4.0 million)**	**($ 2.7 million)**	**($ 6.6 million)**

**No additional administrative costs are anticipated for SFY09.*

APPENDIX E - FOCUS GROUP QUESTIONS

Participants:

1) Application process – what is easiest? What would you like to see?
2) Do you currently have access to a PC connected to the Internet?
3) Would you prefer to apply for BadgerCare in-person, through the mail or through the Internet? Have you used ACCESS?
4) Have you dropped employer sponsored insurance in order to enroll into BadgerCare (Medicaid)?
5) Do you currently have *access* to individual health coverage through your employer? family coverage?
6) If you were offered private insurance through your employer, would you enroll? What would be the deciding factor?
7) If you considered purchasing health insurance in the past, but chose not to, why didn't you? (premium cost, co-pays and deductibles, or coverage)
8) How important to your enrollment decision are non-medical or other additional benefits, such as dental, vision, substance-use treatment or mental health services?
9) What do you think are the major differences between a Medicaid/BadgerCare benefit package and a private insurance benefit package?
10) What do you know about the current Medicaid/BadgerCare eligibility requirements for children, pregnant women and parents? Do you understand the requirements?
11) If the program were made simpler, for instance if we just had a straightforward gross income test, would you be more likely to apply for the program? Is it difficult to understand current program requirements and what the forms ask for?
12) Which would you prefer – higher monthly premiums and lower co-pays or the opposite?
13) What amount of monthly premium would you be willing to pay for yourself (adult) or for your children to receive full health insurance coverage?
14) What amount of co-pay would you be willing to pay for yourself or for your children for doctor visits? What about for prescription drugs?
15) If you are a current BadgerCare or Medicaid recipient, what *one* change would make the program better for you?
16) If you are a current BadgerCare or Medicaid recipient, what *one* change would have the most significant negative effect on you?
17) If you are a current BadgerCare or Medicaid recipient, how satisfied are you with the quality and accessibility of the health care you receive?
18) Where do you go to get information on available health-related benefits?
19) What is your perception of Medicaid/BadgerCare?
20) What experiences with private or public insurance do you have – positive or negative?
21) If offered through your health insurance, would you attend smoking cessation or weight management programs?

Providers:

1) What are the impediments to taking Medicaid patients?
2) *When they answer "the reimbursement rates are too low" then ask:* What besides the rates being too low are impediments to taking Medicaid patients?

3) What do you think will motivate participants to enroll in weight management, smoking cessation, or other prevention programs?
4) How could we simplify the program for you and recipients?
5) How do you prefer to get information about available state health programs?
6) What incentives would have the most significant positive effect on patient health?
7) How can we encourage appropriate use of the ER for emergency care only?
8) What program element has the biggest effect on service utilization? Premiums, benefit structure, co-pays?
9) What one thing could the State do, besides raising rates, to help you provide quality care to more recipients?
10) What strategies are effective in getting pregnant women into care early?

Health insurance for all kids

Affordable, comprehensive health care coverage for all children in Wisconsin